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TESTIMONY RE: **Raised Bill RAISED BILL NO. 459 AN ACT CONCERNING MEDICAL ASSISTANTS.**

PUBLIC HEALTH COMMITTEE

March 19, 2014

Good Afternoon, Senator Gerrantana and Representative Johnson and esteemed members of the Public Health Committee. Thank-you for the opportunity to provide testimony on behalf of the Connecticut Nurses' Association (CNA) related **RAISED BILL NO. 459 AN ACT CONCERNING MEDICAL ASSISTANTS.**

I am Mary Jane Williams Ph.D., RN current chairperson of Government Relations Committee for the Connecticut Nurses Association and professor emeritus from Central Connecticut State University. I speak in strong opposition **Raised Bill RAISED BILL NO. 459 AN ACT CONCERNING MEDICAL ASSISTANTS.**

The average training of a Medical Assistant is outlined as:

> Medical assistant training occurs in post-secondary schools that offer medical assistant training programs. educational standards for Medical Assisting. They also need to offer sufficient classroom and lecture time. The entire program will need to have a total of 900 hours, which already comprise the lectures, laboratory, and also the 225 hours of externship. The program contains four modules together with the externship since the final module. The focus of the

very first 3 modules is to teach trainees to perform healthcare and also administrative responsibilities efficiently. The physician or surgeon supervises the medical assistant in a place where you live with the medical responsibilities as well as processes that they carry out. The opportunity to work in real-life hospital circumstances is done during the externship. The graduates of a medical assistant training program are not required to get a certification or permission to practice.

Medical Assisting is the ideal job for those individuals who desire to venture in the medical field, nevertheless does not desire to study for several years.

The process of administration of Medication is not a simple task. It requires skill, knowledge and judgment. In order to correctly administer medications the individual who is responsible for administering the medication must be able to assess the patient, as this is the first step in the process of Medication Administration. Assessment of patients is not a competency that is in the medication assistant curriculum. Therefore the medication assistant will be taking an order from a Physician and administering medication without the any depth of knowledge related to a potential diagnosis and treatment. Without understanding the diagnosis or multiple diagnoses and how they relate to the pharmacologic aspects of the drug. The medication Assistant is uninformed about the knowledge and process essential to the administration and follow up assessment, which includes any potential issues, allergic reactions and/or contraindications experienced with the Medication. The Medication Assistant does not have the education essential to client health and safety and/ or the ability to foster continued adaptation, which is essential to this process.

The Registered Nurse is responsible for collection of data, assessment, and medication administration after checking the order for the five rights, determines which Medications to give, follows up to determine the response to the Medication, annotates appropriately and provides guidance and education for the patient.

It has been reported by the American Nurses Association in a formal statement that

medication errors are among the most common medical errors, **harming at least 1.5 million people annually**. **The same report cites the extra medical costs associated with treating drug related errors occurring in hospitals alone amount to $3.5 billion per year**. (Institute of Medicine of the National Academies, July 2006). **Since errors occur, not just in hospitals, but in multiple settings, this is believed to be a conservative estimate. Medication errors are attributed to a number of system failures, including the process of administration. The Institute of Medicine's (IOM) 1999 report,**

"To Err is Human" has served as a blueprint for improvements in the health care system, recommending a number of strategies shown to reduce errors in the medication process. **In spite of some progress in implementation of some of the suggestions, the number of errors continues to be staggering. This is compounded by the belief there is underreporting of errors in general.** Underreporting has, in part, been attributed to a failure of a standardized definition of an error. Is a "near miss" reportable? Another contributing factor is the fear of reprimand that still pervades the psyche of some practitioners. Although there has been no documentation pointing to administration errors resulting from harried nurses and inadequate staffing, this is likely less about identifying the root cause, but more about what is reported.

The 1999 IOM report recognized the complexity associated with medication administration and in particular the multiple tasks performed by nurses. What was lacking at that time is recognition of the cognitive processes in which nurses engage while administering medications. The processes nurses use during medication administration to prevent errors, prevent harm and promote therapeutic responses are not well known. Studies of nurses and nursing students thinking processes have produced inconsistent findings, complicated by the multiplicity of terms. **However, the Journal of Nursing Scholarship (First Quarter 2007) described a study designed to explain nurses' reported thinking processes during medication administration. The study revealed ten descriptive categories of nurse's thinking: communication, dose time, checking, assessment, evaluation, teaching, side effects, work-arounds, anticipatory problem solving, and drug administration. The researchers concluded that nurse's thinking processes extend beyond rules and procedures as nurses use patient data and interdisciplinary knowledge when administering medications. The study demonstrated the considerable use of the nurse's clinical knowledge, experience and understanding of patient's patterns of response and potential problems when engaged in the medication process**. **For example, nurses integrated their knowledge of patient's laboratory values and pattern of individual patho- physiological responses to determine the need for a change in drug dose or time and subsequent communication to the prescriber. Checking for the correctness and validity of the order is a step in thinking that has resulted in the reduction of errors, commonly known as near misses. The**

technical portion of medication administration includes the commonly held steps, known as the five rights, the right: patient, medication, dose, route, and time. Wilson and DiVito-Thomas (2004) proposed a sixth right to the well established five rights of medication administration, that of "the right response of the patient to the medication". This right can be equated to the nurse's thinking associated with evaluation. Another example of nurses' thinking include what the researchers referred to as work a-rounds, representing the thinking about steps nurses need to use to bypass procedures in order to expedite getting drugs to the patients in a more timely fashion for a therapeutic response. This study found the actual act of administering a medication is a small part of the professional role in medication administration. The ten categories of thinking during medication administration indicate the intellectual complexity of the process.

The National Council of State Boards of Nursing (NCSBN) in the October 2011 issue of the Journal of Nursing Regulation reported the research findings of the first national survey of medication aides. The data from this study imply that a disparity exists between regulation and practice. Medication aides reported being required to take on responsibilities beyond their defined role and training, some without sufficient supervision, if any. So what does this mean for states in which assistive personnel are or may become authorized to administer medications? Although the "task" has been shifted to assistive personnel, responsibility for the nursing care outcome remains with the nurse. Is the delegation of medication administration to assistive personnel whose training requirements are mot standardized the best approach to ensuring the delivery of safe and quality nursing care? Like so much of the practice of registered nurses, it is not about tasks. Nurses must be present when policy and statutory changes are being discussed and be prepared to describe what unique contributions they make and recognize the implications associated with proposed changes. Also, strict compliance with state regulations, appropriate education and adequate supervision are essential. (Janet Haebler MSN, RN, Associate Director, ANA State Government Affairs at janet.haebler@ana.org.)

What is being asked for in this Proposed legislation is permission for Physician to hire the lowest level health provider and then allow them to administer Medications without the necessary knowledge base that facilitates the safe administration of Medications, with the safe follow-up by an individual who has the education to support the behavior.

I completely understand the impetus and reasoning behind this request and I am aware that some practices are already utilizing Medication Assistants in their practices. I have also had multiple calls from Registered Nurses who have lost

their jobs because of the change in the Physician based practices. This does not make Medication Assistant medication administration SAFE and/or Acceptable.

I have spoken with several physicians who have rather large practices. They have Registered Nurses administering all their Medications. They believe it is much safer to employ a professional licensed nurse. They recognize the importance of the education on the patient outcome. These Physicians utilize Medical Assistants as support in activities they are qualified to perform and I have also discussed this issue with others who employ only Medical Assistants. The real issue is many of these individuals do not know what they do not know, this is a very dangerous trend.

I know many states utilize this system. That also does not make it the correct way to administer medication. The office practice may save money by utilizing this system but we need to ask ourselves what it will cost the patient, the health care system and the state?

I urge you to vote against Raised Bill RAISED BILL NO. 459 AN ACT CONCERNING MEDICAL ASSISTANTS. It is our responsibility to protect the health of the public we serve.

Thank you

Mary Jane M Williams PhD., RN